



MY HEALTH LA

One-e-App Eligibility & Enrollment Training



Presented by: Los Angeles County - Department of Health Services
MHLA Eligibility & Enrollment Training Unit



WELCOME & INTRODUCTIONS

What is My Health LA (MHLA)

Available in seven (7) languages:

- English
- Spanish
- Armenian
- Chinese
- Korean
- Tagalog
- Thai

What is the My Health LA program?

- My Health LA is a NO-COST health care program for low-income residents of Los Angeles County who do not have health insurance.
- My Health LA is a program where members can get ongoing, quality health care from a team of health care providers at community clinics.
- My Health LA is a way for uninsured County residents to get healthy and stay healthy!

Who is eligible for My Health LA?

My Health LA is for people:

- ✓ Who live in Los Angeles County
- ✓ Age 19 and older
- ✓ Meet income requirements (see back of fact sheet)
- ✓ Lack or not eligible for health insurance

My Health LA is NOT health insurance—
If you have health insurance, do not drop it!

How can I find out if I am eligible? Where I can enroll?

- Call Member Services at 1-844-744-6452 (MHLA). Member Services is open from 8:00 am to 5:00 pm Monday through Friday.
- Call your medical home clinic in advance to schedule an appointment or to enroll. Make sure the clinic is accepting new patients. It is free to apply!
- For more information, visit: dhs.lacounty.gov/mhla



What health care can I get through My Health LA?

- My Health LA members get FREE basic medical care that includes:
 - ✓ Ongoing Primary Preventive Care and Health Screenings
 - ✓ Health Information and Advice
 - ✓ Specialty Care at Department of Health Services (DHS)
 - ✓ Hospital inpatient, urgent & emergency care at DHS clinics & hospitals
 - ✓ Prescription Medicines
 - ✓ Laboratory Services and Tests
 - ✓ Other Related Health Care Services
- My Health LA members can get primary medical care at one of 193 participating community clinic sites in Los Angeles County.

What are some of the benefits of My Health LA?

- My Health LA is patient-centered care. Members will choose a Medical Home Clinic, and will receive ongoing care at that clinic throughout the year. You may only have one Medical Home clinic in the My Health LA program.
 - ✓ A Medical Home is a clinic where patients see a primary care doctor or a nurse who knows their patients and understands their medical history
- My Health LA members can choose a Community Clinic and can make their own appointments at that clinic.
- You don't have to wait until you are sick to get medical care—you can get free check-ups and preventive care at your medical home clinic
- You get an ID card to show you are a member of My Health LA.
- You can call the toll-free Member Services line from 8:00 am to 5:00 pm Monday through Friday. Agents can assist you in many languages.



Eligibility Review Requirement Documents

Recommended OEA Options for Race
Alaskan Native
Asian
Asian Indian
Black/African American
Cambodian
Chinese
Declined to State
Filipino
Guamanian or Chamorro
Japanese
Korean
Native American Indian
Other or Mixed Race
Pacific Islander/ Native Hawaiian
Samoa
Vietnamese
White

Recommended OEA Options for Gender
M = Male
F = Female
O = Other

Recommended OEA Options for Identification
CA Driver's License or ID
California DMV Identification
Valid Department of Motor Vehicles ID Card
Military ID/Draft Record
Military Dependent's ID Card
School Record w/Parent's Name
Cert of Indian Blood
Has Verified ID in CalWin
Employment Auth/Picture ID
Foreign Driver's License or ID
Consular ID
Student Picture ID
Temporary Resident Card
Affidavit of Identity
Law Enforcement/Corrections Verified ID
Law Enforcement/Corrections ID
Other Government Issued ID
Legally responsible relative's picture and address
Foreign Passport
SSA Verified ID

Recommended OEA Options for Residency
CA Driver's License or ID
Valid Department of Motor Vehicles ID Card
Government Issued ID
Student Picture ID
Rent Receipt issued within last 60 days for applicant and or spouse
Utility Bills issued within last 60 days for applicant and or spouse
Letter addressed to applicant and postmarked within the last 60 days
Letter from person providing you with free housing, utilities and/or food
Check stub with address
Other documents showing an address may be accepted. Applicant may sign an affidavit of residency under certain circumstances (See DHS Policy 515.1)
The Affidavit of residency may be used for proof of Los Angeles County residency if no other proof is available. (If the patient is homeless, and using a P.O. Box, indicate the P.O. Box as their mailing address.)

Eligibility Review Requirement Documents

Recommended OEA Options for Disenrollment	Recommended Allowable OEA Earned Income	Recommended Allowable OEA Unearned Income
Not a Los Angeles County resident	Earnings from job	Alimony
Enrolled in public Coverage	Cash Income	Cash Contribution
Enrolled in Employer-Sponsored Insurance	Fulltime Student Income	Child Support
Enrolled in Private Insurance	Other Income	Disability
Participant is Deceased	Self-Employment	Educational Grants, Scholarships, or Financial Aid
Program Dissatisfaction (admin, services, medical home, etc.)	Self-Employment Partnership	Gambling
False or Misleading Information on MHLA Application	Worker's Compensation	Cash Gifts
Under Program Age Requirement		In-Kind Income Benefits
Enrolled in Pre-Existing Condition Insurance Plan		Interest Income/ Ordinary Annuity Income
Enrolled in Full scope-Medi-Cal		Loans
Did Not Complete Renewal		Other Gross Taxable Income
Determined Eligible for Other Programs		Payments From Annuities
During Annual Renewal or Modification		Pensions
Enrolled in My Health LA Program: Unable to obtain Proof of Citizenship or Identity on behalf of Enrollee		Railroad Retirement Benefits
Enrollee is Incarcerated		Rental Income
Member's Request		Retirement, Survivors, Disability Insurance
Income exceeds 138% of FPL		Social Security Administration Payments (SSA)
		Social Security Early Retirement
		Social Security Retirement
		Social Security Survivors Benefits
		State Disability Insurance (SDI)
		Tax Refund
		Unemployment Compensation
		Veteran's Benefits
		Worker's Compensation

Eligibility Review Requirement Documents

Recommended MHLA Denial Reasons
Not a Los Angeles County Resident
Enrolled in public Coverage
Participant Request
Incomplete Application
Participant has DHS Primary Care Provider
Enrolled in Full scope-Medi-Cal
Did not Complete Renewal
Determined Eligible for Other Programs
Durning Annual Renewal or Modification
Enrollee is Incarcerated
Income exceeds 138% of FPL
Enrolled in Employer-Sponsored Insurance
Enrolled in Private Insurance
False or Misleading Information on MHLA Application
Under Program Age Requirement
Participant is Deceased
Program Dissatisfaction (admin; services; medical home; etc.
Duplicate Application

Medical Home Change
Enrollment occurred in last 30 days
Change of Address (Home/Work)
Change in Medical Condition
Change in Age or Personal Characteristic
Deterioration of Relationship with Provider
Closure of Clinic site
Management Approval

Medi-Cal Denial Reasons
Client Deceased
Application Withdrawn
Moved Out of State
Loss of Contact/Unable to Locate Applicant
Failure to Cooperate
Does Not Meet California Residency Requirements
Excess Resources
No Program Linkage
Potential State Only Program Eligible did Not apply for ongoing Medi-Cal
No Deprivation
Living in a Public Non-Medical institution
Existing CalWORKS/Medi-Cal/CMSRP Recipient
Existing SSI/SSP Recipient
Receiving Medicaid in Another State
Duplicate Pending Application
IE/RR terminates accelerated enrollment (MEDS Generated)
Other
Applicant can't apply for the person on the application
Erroneously Reported Application
No Valid Data Reported (MEDS Generate)
Premium Not Paid
Income Does Not Meet Requirements
Home Address State Missing or Invalid
End Date for Employer Sponsored Insurance Missing or Invalid
Child is Eligible for Medicare Part A and B
Funding Not Available
Child age 19 or over not eligible HFP
Previous Hospital Presumptive Eligibility for same pregnancy (HPE use only)
Over age Limit for Hospital Presumptive Eligibility (HPE) use only
Application for IAP Denial (Includes MAGI and APT C/CSR)
Not Part of the Tax Household

Medi-Cal Denial Reasons (Conti.)
Excess Income - Denial for MAGI and Qualified for APTC/CSR)
Other Minimum Essential Coverage
Incarcerated
Not a US Citizen, National or Lawfully Present

Acceptable Verification various income sources
Copy of most recent paystub (from less than 45 days)
Statement from employer about your job (how much you are paid, how often and how many hours you work)
Last year's Federal Income Tax return (and "Schedule C" if self-employed)
Three months of current business records (if income tax return is not available or does not represent current earnings)
Income Property (if renting property)
Award Letter or check/copy of check from any of the following income sources: (select one)
<ul style="list-style-type: none"> • Unemployment insurance Benefits (UIB) • Disability Insurance Benefits (DIB) • Veterans Benefits • Social Security Benefits • Railroad pension • Retirement Benefits • Interest Income • Educational grants • Cash contributions from relatives/friends
Self Affidavit from Applicant for earned/unearned income.
Direct Deposit Statement for Unearned Income
Signed statement from person or organization providing cash contribution.
Letter from person providing you with free housing utilities and/or food (In-Kind Income)
<ul style="list-style-type: none"> • Other Unearned Income (specify)_____



Introduction to One-e-App

- ✓ Demographic Search
- ✓ Process MHLA applications
- ✓ Modify and update existing MHLA applications
- ✓ Process Annual renewals
- ✓ Disenrollment/Deny MHLA applications
- ✓ Generate Reports

Performing a Demographic Search

Before you start an application you must perform a demographic search to see if the person has or previously had MHLA. This can be performed by using the Search for Person/Application link on the Dashboard. When you click on the link, you will have the ability to search for a patient using the following information, unique identifier or personal information.

Search for an Application

Before beginning a new application, you must perform a search to find out whether the applicant(s) already exists in the system. Please specify at least two criteria or a unique identifier by which you would like to search.

Search Type
☐ Save current selection as my default selection

Result Type

Unique Identifier

Application ID

Person ID

Social Security Number

Person Detail

First Name

Middle Name

Last Name

Suffix

Gender ☐ Male ☐ Female

Date of Birth

Mothers Maiden Name

Contact Detail

Phone 1

Phone 2

E-Mail Address 1

E-Mail Address 2

The search results can be further filtered by person's place of birth, the assistor's name, the application date range and/or the Eligible Program Name.

- ☐ Person Place of Birth
- ☐ Application Assistor
- ☐ Date Range
- ☐ Eligible Program Name

Search Options

- ✓ Unique Identifier
 - a. Application ID
 - b. Person ID
- ✓ Person Detail (At least two)
 - a. First Name
 - b. Middle Name
 - c. Last Name
 - d. Gender
 - e. Date of Birth (DOB)
 - f. Mother's Maiden Name
- ✓ Contact Detail
 - a. Phone
 - b. E-mail Address

Begin MHLA Application


step 1: Getting Started
logout

One Stop Access to Apply for Assistance

Change Font Size ▲ A A A

1 Getting Started
2 Your Household
3 Household Income
4 Other Information
5 Preliminary Eligibility
6 Additional Information
7 Program Information
8 Next Steps

Consent to Share Information

To determine if you or someone in your household is eligible for benefits to help cover your health care costs you will need to provide us with some personal information. The information collected will be used only to determine if you qualify for benefits under a specific health care plan and may be shared with other agencies and organizations that administer these plans. The information you provide may, upon your approval, be submitted to these agencies.

If you do not agree to share your information, your personal information will not be collected electronically. You may still complete separate paper applications for any benefit plan for which a paper application exists. If a plan does not have a paper application and you do not agree to share your information, you will not be considered for benefits from that plan, and it is possible that you will not receive benefits for which you qualify.

Your information may be shared with these agencies and organizations:

- Los Angeles County Hospitals and Clinics
- Los Angeles County Department of Public Health
- Los Angeles County Department of Public Social Services
- Los Angeles County Non-profit Hospitals
- LA Care Health Plan
- Health Net Health Plan
- Healthy Kids
- Participating Community Partners

These agencies may be required to share your personal information with other agencies or organizations not listed here in order to process your application or perform business functions related to the administration of these benefit plans.

Do you give permission to share your personal information from this application with the above agencies? ☒ Yes ☐ No ?

Print

Get Help
Report a Bug / Make a Suggestion


Next

MHLA Application

- 1 Getting Started
- 2 Your Household
- 3 Household Income
- 4 Other Information
- 5 Preliminary Eligibility
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
Tell us about yourself


 Notes


Are you a member of the household? ☒ Yes ☐ No 


+ First Name 


Middle Name ☐ None 

Last Name 

Suffix (Jr, Sr, etc.) 

Do you use any other names?
(nicknames, maiden, etc.) ☐ Yes ☒ No 

E-mail ☐ None 


Home Phone 


Cell Phone 

Work Phone x 

Message/Emergency Phone x  

How would you like to be contacted? 

What is your primary spoken language? 

What is your primary written language? 

[View Application Summary](#) | [Get Help](#)

[Next](#)

MHLA Application

Are you a member of the household? ☒ Yes ☐ No ?

+ First Name ?

Middle Name ☒ None ?

Last Name ?

Suffix (Jr, Sr, etc.) ?

Do you use any other names? (nicknames, maiden, etc.) ☐ Yes ☒ No ?

E-mail ☒ None ?

Home Phone ?

Cell Phone ?

Work Phone x ?


Message/Emergency Phone x ??

Can we send alert messages to your cell phone? ☒ Yes ☐ No

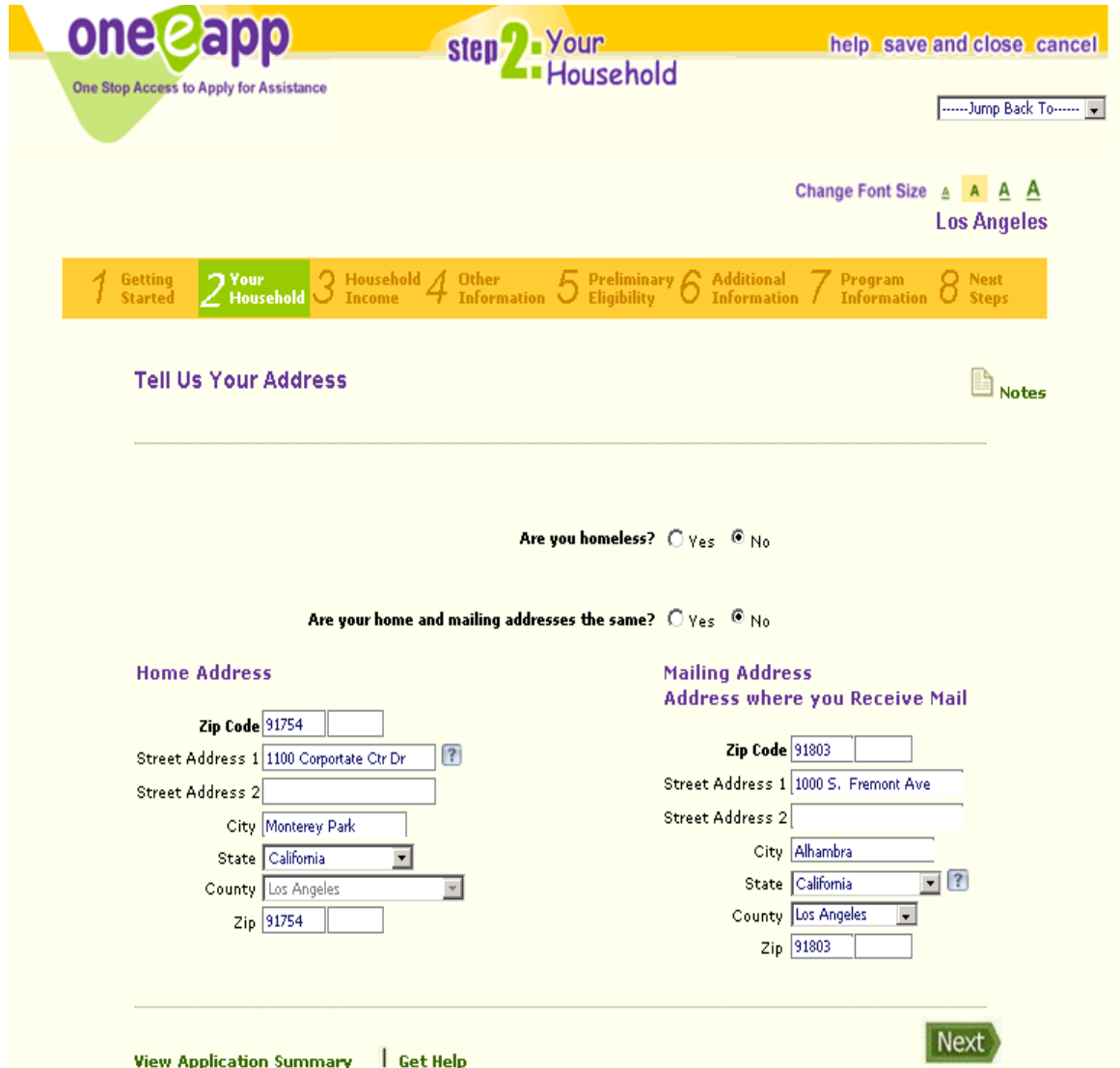
How would you like to be contacted? ?

What is your primary spoken language? ?

What is your primary written language? ?

- ✓ Enter the Primary Informant's information
- ✓ Name
- ✓ If no middle name  none
- ✓ Email address
- ✓ Home, Cell, Work and Message/Emergency phone # if applicable
- ✓ Applicant has the option to be contacted through home phone, cell, or regular mail
- ✓ Indicate primary spoken and written language

MHLA Application



The screenshot shows the 'oneeapp' interface for the MHLA Application, specifically 'step 2: Your Household'. The header includes the 'oneeapp' logo, the tagline 'One Stop Access to Apply for Assistance', and navigation links for 'help', 'save and close', and 'cancel'. A 'Jump Back To' dropdown menu is also present. Below the header is a progress bar with eight steps: 1 Getting Started, 2 Your Household (current step), 3 Household Income, 4 Other Information, 5 Preliminary Eligibility, 6 Additional Information, 7 Program Information, and 8 Next Steps. The main section is titled 'Tell Us Your Address' and includes a 'Notes' icon. It contains two sets of address fields: 'Home Address' and 'Mailing Address' (labeled 'Address where you Receive Mail'). Each set includes fields for Zip Code, Street Address 1, Street Address 2, City, State, County, and Zip. Below the address fields are two questions: 'Are you homeless?' and 'Are your home and mailing addresses the same?', each with 'Yes' and 'No' radio button options. At the bottom, there are links for 'View Application Summary' and 'Get Help', and a 'Next' button.

One E App allows you to enter:

- ✓ Home Address
- ✓ Mailing Address
- ✓ Applicant will have the option to choose to have his/her mail for MHLA sent to their selected Medical Home.

Application - Continued

Tell us more about John Doe

Notes

Is this person applying for benefits? ☒ Yes ☐ No

Gender ☒ Male ☐ Female ☐ Other

Date of Birth 

Mother's Maiden Name ☐ Unknown

Place of Birth **(Select the one that applies)**

California County or

US State or

Other Country

Are you Hispanic or Latino? ☐ Yes ☒ No

What is your race?
(You may select up to 2 races with which you most closely identify)

SSN ☐ Yes ☒ No

Do you know your SSN? ☐ Yes ☒ No

US Citizen ☐ Yes ☒ No

Do you have Legal Permanent Resident or other satisfactory immigration status? ☐ Yes ☒ No

Date Legal Permanent Status Received

Prucol Alien ☐ Yes ☒ No

Date of Entry to U.S. 

Marital Status

Spouse's First Name

Spouse's Middle Name ☐ None

Spouse's Last Name

Suffix

[View Application Summary](#) | [Get Help](#)

[Report a Bug / Make a Suggestion](#)

Application ID: 19002201418900720

[Next](#)

- ✓ Applying for aid (Y/N)
- ✓ Enter applicant's gender
- ✓ Date of birth
- ✓ Mother's maiden name
- ✓ Place of birth
- ✓ Ethnicity
- ✓ Race
- ✓ Social Security Number (if applicable)
- ✓ If U.S. Citizen
- ✓ Legal permanent resident and date received
- ✓ Date of entry into the United States (optional)
- ✓ Marital Status
- ✓ Spouse's name

Application - Continued

Change Font Size 

Los Angeles

- 1 Getting Started
- 2 **Your Household**
- 3 Household Income
- 4 Other Information
- 5 Preliminary Eligibility
- 6 Additional Information
- 7 Program Information
- 8 Next Steps

Adult(s) : John Doe

Tell us more about John Doe

 Notes

Is John Doe currently enrolled in any public benefit program(s)? ☐ Yes ☐ No

Does John Doe have other private health insurance? ☐ Yes ☐ No

Does John Doe currently have employer paid insurance? ☐ Yes, covered now
☐ Not now, but during the past 180 days
☐ No, but employer offers insurance
☐ No

Has John Doe been denied Medi-Cal coverage? ☐ Yes ☐ No

Are there any more persons in the household? ☐ Yes ☐ No


[View Application Summary](#) | [Get Help](#)

Next 

Insurance Inquiry

- ✓ Is the applicant enrolled in any public benefit program?
- ✓ Does the applicant have private insurance?
- ✓ Does the applicant have employer paid insurance?
- ✓ Is the applicant eligible for insurance through employer ?
- ✓ Has the applicant recently been denied Medi-Cal benefits?

Application – Household Summary



step 2: Your Household

help save and close c

One Stop Access to Apply for Assistance

-----Jump Back To

Change Font Size A A A A Los Angeles

1 Getting Started

2 Your Household

3 Household Income

4 Other Information

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8 Next Steps

Household Summary

Notes

Please make any necessary changes.

To remove a person from the application, click on the 'Remove' link next to each person name.

Name	Applying for coverage	Remove
John Doe (Primary Informant)	Yes	

To add additional household members to the application, answer Yes to the following question and click Next.

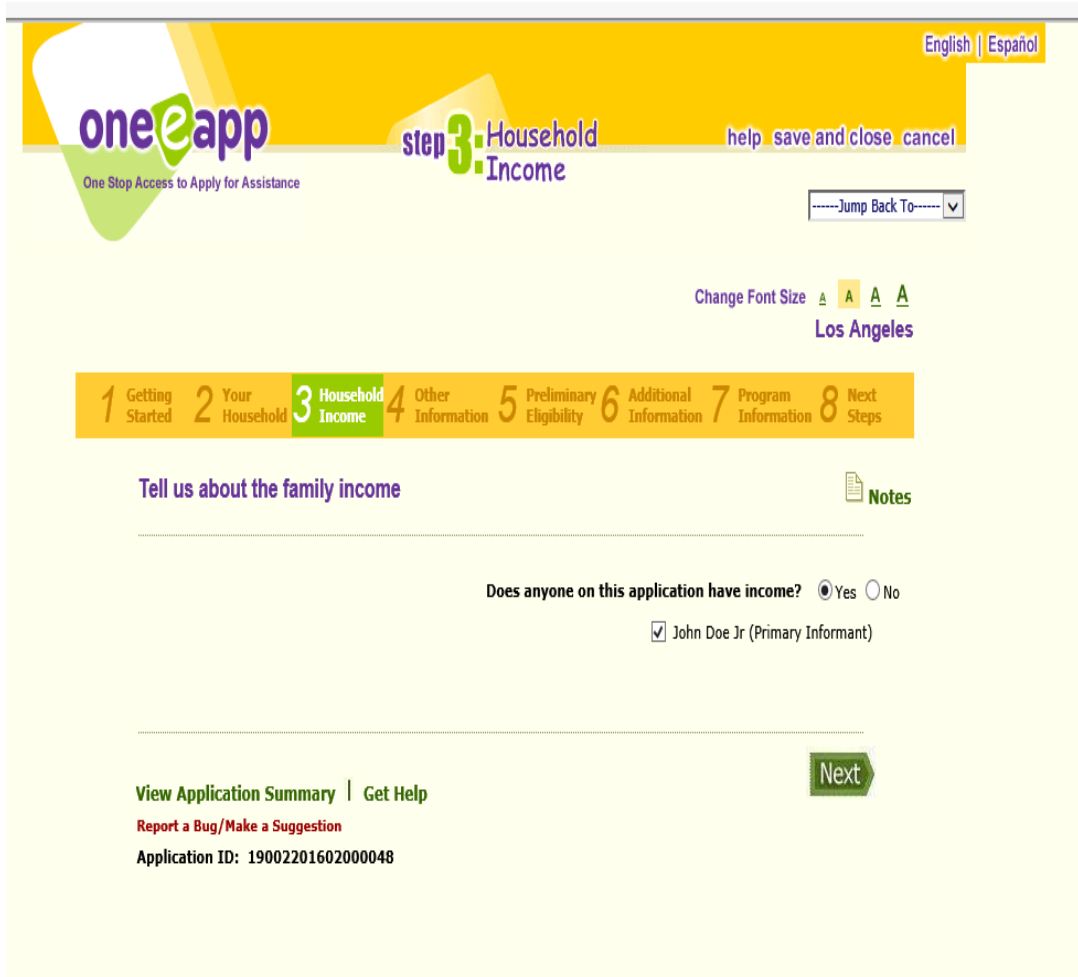
Are there any more persons in the household? ☐ Yes ☒ No

View Application Summary | Get Help

Next

- ✓ Screen includes all members of the HH
- ✓ Are there any other members in the HH?

Application – Income and Expenses



The screenshot shows the 'oneeapp' interface for 'step 3: Household Income'. At the top, there are language options for 'English' and 'Español', and a 'Jump Back To' dropdown menu. Below the header, there are links for 'help', 'save and close', and 'cancel'. A 'Change Font Size' section includes three icons (A, A, A) and the text 'Los Angeles'. A progress bar at the bottom shows eight steps: 1 Getting Started, 2 Your Household, 3 Household Income (current step), 4 Other Information, 5 Preliminary Eligibility, 6 Additional Information, 7 Program Information, and 8 Next Steps. The main content area is titled 'Tell us about the family income' and includes a 'Notes' icon. A question asks 'Does anyone on this application have income?' with radio buttons for 'Yes' and 'No'. The 'Yes' option is selected, and a checkbox is checked for 'John Doe Jr (Primary Informant)'. At the bottom, there are links for 'View Application Summary', 'Get Help', 'Report a Bug/Make a Suggestion', and 'Application ID: 19002201602000048'. A 'Next' button is also visible.

HH Income/Expenses

- ✓ Enter “Yes” if the applicant is receiving both earned and unearned income.
- ✓ Enter “Yes” even if they are receiving in-kind income.
- ✓ There are no deductions for the MHLA program. The expense inquiry is strictly used for the Medi-Cal and Covered California Programs.

Application – Income Screen

Does John Doe have any income? ☒ Yes ☐ No

Current Situation	Income Source	Frequency	Gross Amount
Other Income	In-Kind Received	Monthly	\$272.00

Gross monthly income for John Doe is \$ 272.00

Please select the type(s) of In-Kind Income received ☒ Housing ☒ Utilities ☒ Food

Name of employer, organization, or person providing the income

Address 1 ?

Address 2 ?

Employer City

State ?

Zip ?

Employer Phone Number ?

Date Received/Expected to be Received ?

Pay Period Begin Date ?


Has this income been terminated? ☐ Yes ☒ No

Does John Doe have any additional income? ☐ Yes ☒ No

- ✓ Is the applicant employed?
- ✓ What is the source of the applicant's income?
- ✓ Self employed?
- ✓ Frequency of pay?
- ✓ Amount received/earned?
- ✓ Please note that if receiving in-kind income (earned or unearned), always enter the applicant as having income.




Application – Income Summary Screen

One Stop Access to Apply for Assistance

step 3: Household Income

help save and close cancel

-----Jump Back To-----

Change Font Size 

Los Angeles

1 Getting Started

2 Your Household

3 Household Income

4 Other Information


5 Preliminary Eligibility

6 Additional Information

7 Program Information

8 Next Steps

Household Income Summary

 Notes

Review the following summary to make sure you have included everyone's income correctly.

To change the income, Click on the person's name.

To remove a person's income from the application, Click on the 'Remove' link corresponding to that person.

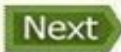
John Doe (Adult)

Sample Self Affidavit of Income Letter

Income Type	Frequency	Amount	Gross Monthly Amount	Remove
In-Kind Received	Monthly	\$272.00	\$272.00	Remove

Sample Profit and Loss Statement

[View Application Summary](#) | [Get Help](#)



One-e-App Person Clearance Screen

English | Español

oneeapp

One Stop Access to Apply for Assistance

step 4: Other Information

help save and close cancel

Jump Back To

▼

Change Font Size

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Los Angeles

1 Getting Started

2 Your Household

3 Household Income

4 Other Information

5 Preliminary Eligibility

6 Additional Information

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8 Next Steps

One-e-App Person Clearance

Notes

Please review the results of the One-e-App person clearance and indicate whether the person has used One-e-App to apply for health care assistance programs. If you select a name below, the associated Person ID will be applied to the individual in this application.

Re-run Person Clearance with Expanded Search

The system has run person clearance by using the default parameters. If you cannot find one or more persons on the application and believe that they should exist in the system, please click the above button to rerun the person clearance search with the expanded search criteria.

John Doe Jr

Score	Person Name	Person ID	Current Application ID	Date Of Birth	Place Of Birth	Gender
No matching records were found.						

☒ The person is not known to One-e-App

Note:

Indicates that the person is a potential match based on SSN and/or address and other household members.

View Application Summary | Get Help

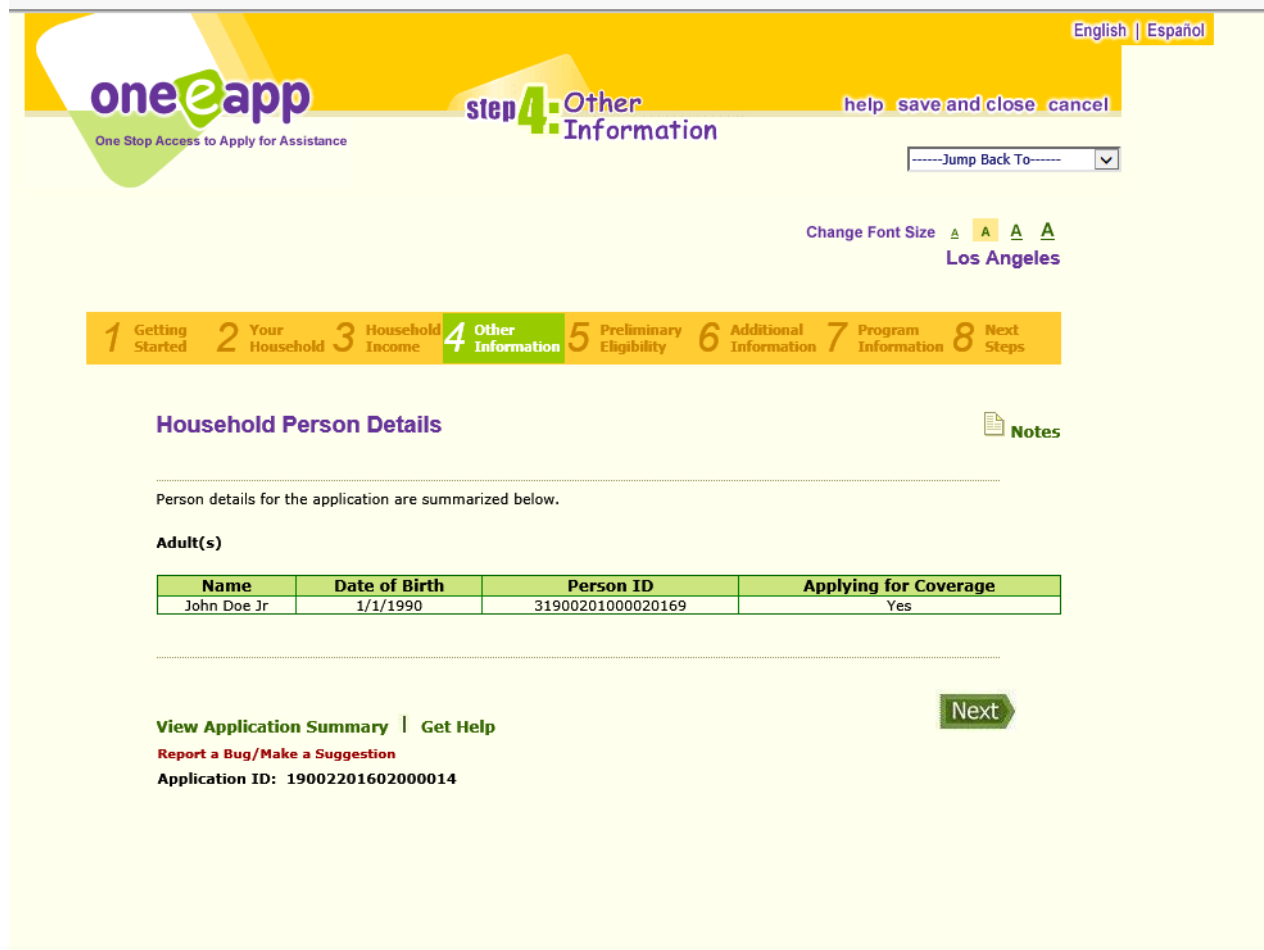
Report a Bug/Make a Suggestion

Application ID: 19002201602000014

Next

- ✓ At this point One-e-App will verify if the Participant or any household members have previously applied for MHLA
- ✓ If Participant(s) is previously known to One-e-App there will be an option to choose the known PID
- ✓ If the Participant(s) are not known to OEA continue and click "next", this will prompt One-e-App to generate a NEW PID

One-e-App Person Clearance Screen



English | Español


oneeapp
One Stop Access to Apply for Assistance

Step 4: Other Information help save and close cancel

-----Jump Back To-----

Change Font Size A A A A
Los Angeles

1 Getting Started 2 Your Household 3 Household Income 4 **Other Information** 5 Preliminary Eligibility 6 Additional Information 7 Program Information 8 Next Steps

Household Person Details  Notes

Person details for the application are summarized below.

Adult(s)

Name	Date of Birth	Person ID	Applying for Coverage
John Doe Jr	1/1/1990	31900201000020169	Yes

[View Application Summary](#) | [Get Help](#)

[Report a Bug/Make a Suggestion](#)

Application ID: 19002201602000014

[Next](#)

- ✓ Household summary
- ✓ Please remember to enter all information correctly
- ✓ This will prevent duplicate PIDs and creating duplicate aid

Application – Preliminary Eligibility Determination



oneeapp
One Stop Access to Apply for Assistance

step 5: Preliminary Eligibility

help save and close cancel

-----Jump Back To-----

Change Font Size A A A

Los Angeles

1 Getting Started 2 Your Household 3 Household Income 4 Other Information 5 Preliminary Eligibility 6 Additional Information 7 Program Information 8 Next Steps

Preliminary Eligibility Determination

Notes

To see which programs or coverages the applicant(s) may potentially be eligible for, click the Calculate button below. This is only a preliminary determination. The application is NOT being submitted at this point.

View Application Summary | Get Help Calculate

Report a Bug/Make a Suggestion

- ✓ One-e-App will now calculate to determine what programs the applicant/s are eligible for.
- ✓ One-e-App will determine eligibility for MHLA for all applicants entered.
- ✓ One-e-App can refer to Medi-Cal and/or Healthy Kids.



Application – Preliminary Eligibility Results

oneeapp
One Stop Access to Apply for Assistance

step 5: Preliminary Eligibility

help save and close ca

-----Jump Back To-----

Change Font Size **Los Angeles**

1 Getting Started **2** Your Household **3** Household Income **4** Other Information **5** Preliminary Eligibility **6** Additional Information **7** Program Information **8** Next Steps

Preliminary Eligibility Results Notes

Based on the information you have provided, the following persons in your household may be eligible for the following programs.

Likely Eligible (More information is required to complete application process in One-e-App.)

Do You Want to Apply?	Person Name	Program Name	Coverage Type	Help
<input checked="" type="radio"/> Yes <input type="radio"/> No	John Doe	Restricted Medi-Cal, No Share of Cost	Primary	
<input checked="" type="radio"/> Yes <input type="radio"/> No	John Doe	My Health LA	Secondary	

View Application Summary | **Get Help** **Next**

Medical Home Selection




The screenshot shows the 'step 6: Additional Information' screen of the oneeapp application. The header includes the oneeapp logo, 'English | Español' language options, and 'help save and close' links. Below the header, it says 'My Health LA' and 'Change Font Size' with three size options (A, A, A). A progress bar at the top shows eight steps: 1 Getting Started, 2 Your Household, 3 Household Income, 4 Other Information, 5 Preliminary Eligibility, 6 Additional Information (current step), 7 Program Information, and 8 Next Steps. The main section is titled 'Medical Home and Selection' and includes a 'Notes' icon. The form fields are: City (dropdown menu), Zip Code (dropdown menu), Medical Home Location (dropdown menu), Status (dropdown menu), and Language (dropdown menu). The City dropdown menu is open, showing options: No Preference, BELL GARDENS, COMPTON, CULVER CITY, HARBOR CITY, HAWAIIAN GARDENS, LONG BEACH, LOS ANGELES, PASADENA, SANTA CLARITA, SANTA MONICA, VALENCIA, VENICE, and WILMINGTON. At the bottom left, there are links for 'View Application Summary' and 'Get Help'. At the bottom right, there is a 'Next' button.

This screen is where you conduct a search for a medical home. You can search by city, zip code, and/or language to select a medical home. You will not be able to select a medical home with a closed status (not accepting new applicants). The Participant can select another clinic instead of the clinic they are currently applying at as their Medical Home if they choose to.

Application – Document Verification

Change Font Size A **A** A A
Los Angeles

1 Getting Started 2 Your Household 3 Household Income 4 Other Information 5 Preliminary Eligibility 6 Additional Information 7 Program Information 8 Next Steps

Document Verification  Notes

Please request the following documents from the applicant and note the type of document collected. Submission of required documentation is required to complete enrollment in all coverage programs.

John Doe

☒ Proof of Income (My Health LA)
Verification:
Source:

☒ Proof of County Residency (My Health LA)
Verification:
Source:

☒ Proof of Identification (My Health LA)
Verification:
Source:

☒ My Health LA Rights & Declarations (My Health LA)
Verification:

- ✓ Reference Eligibility Table
- ✓ Enter Received if your applicant has submitted verification and verified by CEC/Application Assistor
- ✓ Indicate source
- ✓ Please remember to print the Participant a copy of the My Health LA Rights and Declarations
- ✓ Only indicate received if documents are present during time of application and scan or fax on to OEA.



Application –Verification Document Summary

English | Español

oneeapp

One Stop Access to Apply for Assistance

step 6: Additional Information

help save and close

My Health LA

Change Font Size ▲ A A A
Los Angeles

1 Getting Started

2 Your Household

3 Household Income

4 Other Information

5 Preliminary Eligibility

6 Additional Information

7 Program Information

8 Next Steps

Verification Document Summary

Notes

Person Name	Verification Document	Verification	Source	Program Name
John Doe Jr	My Health LA Rights & Declarations	Received	N/A	My Health LA
John Doe Jr	Proof of County Residency	Received	Affidavit of County Residency	My Health LA
John Doe Jr	Proof of Identification	Received	Affidavit of Identity	My Health LA
John Doe Jr	Proof of Income	Received	Self Affidavit of Income	My Health LA

Missing Documents

View Application Summary

| Get Help

Report a Bug/Make a Suggestion

Application ID: 19002201602000014

Next

Application – Signature Option


English | Español

oneeapp

One Stop Access to Apply for Assistance

step 7: Program Information

help save and close

Change Font Size  Los Angeles

1 Getting Started

2 Your Household

3 Household Income

4 Other Information


5 Preliminary Eligibility

6 Additional Information

7 Program Information

8 Next Steps

Signature Option

 Notes

Please select a method for submitting your signature from the options below.

☒ I will print the Rights and Declarations page(s) and either fax or scan them using the document cover sheet provided at the end of the application process.

☐ I want to sign using an electronic signature tablet.

View Application Summary | Get Help

Next

Rights and Declaration

Rights and Declarations for My Health LA



Original Application ID: 19002201421600051
Applicant Name John Doe

Certified Enrollment Counselor: Paula Ramos

I declare that:

1. I am a resident of Los Angeles County.
2. My gross monthly family income is at or below 138% of the Federal Poverty Level as indicated on the Los Angeles County website (see below for link).
<http://dhs.lacounty.gov/MHLA>
3. The information I provided in this application is accurate.
4. I am not eligible for and I am unable to obtain Full-Scope Medi-Cal or Share of Cost Medi-Cal to the best of my knowledge.
5. I am not eligible for and I am unable to obtain Medicare Part A or Part B to the best of my knowledge.
6. I am currently unable to obtain any private insurance or obtain insurance through Covered California to the best of my knowledge.

I have read and acknowledge each of the following:

1. I understand that the My Health LA Program is not an insurance program and is only valid at pre-approved Los Angeles County Hospitals, Community Partners, DHS Sites, or pre-authorized referral locations and pharmacies.
2. I understand that I will select a Medical Home clinic and will comply with their pharmacy guidelines.
3. I understand that my eligibility for the My Health LA Program will expire one year from my enrollment date, and that I must reapply to maintain my coverage after twelve months.
4. My eligibility in the My Health LA Program may include retroactive coverage from the first day of the month that I enroll in this program.
5. I understand that my income must be at or below 138% of the Federal Poverty Level.
6. I understand that my eligibility for the My Health LA Program will be reviewed prior to hospital stays or same-day surgeries.
7. I understand that if I become eligible for health insurance during this year, I must notify the Los Angeles County My Health LA Program by contacting Member Services at 1-844-744-6452 and my Medical Home clinic immediately. I understand that failure to do so will result in being billed for all charges after the effective date of my new health insurance coverage.
8. I understand that eligibility for other public programs, such as Medi-Cal, may result in my having additional financial responsibilities that are a part of these programs' requirements.
9. I acknowledge that I have received copies of the My Health LA Program brochure and I agree to abide by Program terms and conditions.
10. I understand that if the information I provide as part of my My Health LA Program application is found to be inaccurate, I will be immediately disqualified from the My Health LA Program. I understand that I may also be billed retroactively for all services provided to me under the My Health LA Program. I further understand that providing false information in order to wrongfully obtain public benefits may also be a criminal offense.
11. I understand that I must contact the My Health LA Program Member Services Department at 1-844-744-6452 within 10 days if there are any changes to my eligibility for this Program, such as changes to my income or place of residency.
12. I understand that the foregoing rights and declarations apply as long as I am a My Health LA Program member. I understand that this rights and declarations form is only required at my initial My Health LA Program enrollment and not during my My Health LA Program renewal.

I declare under penalty of perjury that the above information is true and correct. Further, by signing below, I hereby authorize County personnel, agents or contractors such as the County's contracted pharmacy network, to verify and/or investigate my eligibility.

Applicant Signature

Date

Application Completion Process

Application Completion Process

Notes

My Health LA

Learn More!

Likely Eligible Persons

John Doe

Steps to Complete the Application

1. If you have not printed your application, you may use the **Reprint Program Application** button below.
2. Make sure you have signed and dated all forms that require an applicant signature.
3. One-e-App recommends that you fax or scan your supporting documents into the One-e-App application. How would you like to attach your documents?
 - ☐ I have already faxed or scanned documents or will do so when I finish all applications.
 - ☐ I will fax
 - ☐ I will scan documents and attach the file(s)

When you click "Next", One-e-App will give you what you need to fax or attach scanned documents.
4. Your application will be Submitted for final eligibility determination.

Reprint Program Application

Before the applicant can be enrolled in the MHLA program, the Certified Enrollment Counselor and CEC Supervisor must read and agree to all of the following:

- I attest that the application I am submitting for this applicant(s) is thorough and complete. I understand that a complete application requires the applicant's eligibility documentation (i.e., proof of identification, Los Angeles County residency and income) be uploaded and attached to the electronic application in the One-e-App eligibility and enrollment system. I confirm that I will upload the verification documents reflected and referenced for this application and these applicant(s).
- I further understand that submission of an application via One-e-App without all of the applicant's required documentation (i.e., proof of identification, Los Angeles County residency and income) is considered by the Los Angeles County Department of Health Services to be an incomplete application.
- I further understand that submission of an incomplete application does not constitute a valid enrollment for medical home reimbursement. As a result, the Los Angeles County Department of Health Services will not provide the medical home with monthly reimbursement for program enrollees who have incomplete applications.

☐ Yes, I have read and agree to the terms above.

- ✓ Indicate whether you have "faxed or scanned" the documents, "will fax" or "will scan" the required verification documents
- ✓ You have the option of Reprinting the Program application
- ✓ Read the agreement before submitting application
- ✓ Click on the box indicating that you have read and agreed to the terms above
- ✓ Now you can submit the application to MHLA
- ✓ Please print both fax coversheets if faxing documents

Referring your applicant



LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES
COMMUNITY PARTNERS
MY HEALTH LA

Sep 14, 2015
Application ID: 19002201421600061
Participant ID: 31900201013216148

John Doe
Monterey Park CA 91754

REFERRAL FOR MEDI-CAL APPLICATION

We are referring the above person to apply for Medi-Cal. John Doe appears to meet the Medi-Cal eligibility requirements. The applicant is currently receiving care from our Department.

John Doe has applied for the My Health LA Program. However, as a condition of eligibility to this program, the applicant must apply for Medi-Cal, if potentially eligible, and must fully cooperate in the eligibility determination process, regardless of the level of benefits to which he/she may qualify, (i.e., either full or restricted or with a Share of Cost or without). Failure to cooperate with the Medi-Cal application process may make the applicant ineligible for My Health LA Program.

Thank you for your cooperation in this matter. If you have any questions or need additional information, call me at 626-299-5720

Paula Ramos
Department of Health

Rev: 9-19-2014

- ✓ Make sure each applicant is given a copy of their Medi-Cal Referral Letter.
- ✓ You will be out of compliance if your applicant does not receive a copy of the Medi-Cal Referral Letter.
- ✓ For the MHLA Program you are ONLY required to refer applicants to apply for Medi-Cal. The MHLA Program does not require verification of compliance.

Faxing and Uploading Documents

- ✓ One-e-App has two fax cover sheets for each application – one for permanent documents (i.e., items that do not change such as birth certificate) and one for temporary documents (i.e., items that do change such as income). These fax cover sheets can be used for all programs.
- ✓ Fax cover sheets may be printed during the application process by clicking on “Print Documents Coversheet” during the program submission process (Option1) OR by selecting the “Print Document Coversheet” from your OEA dashboard searching for the application, and clicking on “Fax” under “Retrieve Fax” column (Option 2).
- ✓ For documents that you have in electronic image formats, such as as .pdf, .gif, etc. you may upload them into OEA.
- ✓ Click on “Attach Scanned Documents” from your OEA, and search for the application. In the search results, check the box next to the application for which you want to upload documents and click on “View/Attach scanned Documents” at the bottom of the search results page and upload documents.
- ✓ After you have uploaded documents, you can view them by clicking on “View Scanned Documents” from your OEA dashboard and following the same steps to find the application in the search results and clicking on “View/Attach Scanned Document” at the bottom of the search results page.



Completion of Application

You Are Almost There...!!!



You have provided the information needed to apply for the following programs. Please click on the **Next Steps** links to see what you need to do to perfect your application(s).

Your One-e-App Application ID is: **19002201421600051**

Next Steps Needed

Person ID	Person Name	Program Name	Application Status	Next Steps
31900201013216148	John Doe	Medi-Cal Restricted No Share of Cost	Completed	Next Steps
31900201013216148	John Doe	My Health LA	Completed	Next Steps

Next Steps for All

Please note: Further documentation may be required to complete enrollment.

Click the Next button to return to the 'Menu' screen.

[Generate Notice](#) | [Languages](#)

[Print](#) | [Print Document Cover Sheet](#) | [View/Attach Scanned Documents](#)

[View Application Summary](#)

[Next](#)

- ✓ Print/Generate Notice with application disposition
- ✓ View Completed application summary
- ✓ View all scanned documents for clarity
- ✓ Reprint document cover sheet

Application Summary

Page : of 3

oneeapp
One Stop Access to Health Services

My Health LA Application Summary

Generated By: Ernesto Reynoso
Generated On: 8/6/2014

Household Information

Application ID	19002201421600051	Application Created By	Paula Ramos
creation date	08/05/2014	Assistor Phone Number	(626)299-5720
		Assistor Location	Department of Health Services
Primary Informant Name	John Doe	Assistor Organization	Department of Health Services
In Household	Yes	Assistor Email	paramos@dhs.lacounty.gov
Entity ID	N/A		
Homeless	No		
		Preferred Spoken Language by Household	English
Number of Persons	1	Preferred Written Language by Household	English
Adults	1	Preferred Spoken Language by Primary Informant	English
Children	0	Preferred Written Language by Primary Informant	English
Unborn Children	N/A		
Additional Family Members	0		

Household Address and Contact Information

Home Address 1	N/A	Mailing Address 1	N/A
Home Address 2	N/A	Mailing Address 2	N/A
City	Monterey Park	City	Monterey Park
State	California	State	California
County	Los Angeles	County	Los Angeles
Zip	91754	Zip	91754
Email	N/A		
Home Phone	(213)222-3333	Work Phone	N/A
Message Phone	N/A	Cell Phone	(213)333-2222

Adult Details

Person Sequence Number	1	Person ID	31900201013216148
Name	John Doe	SSN	No
Gender	Male	Pseudo SSN	N/A
Date of Birth	01/01/1982		
Relationship to Applicant	N/A	Place of Birth	Mexico
Applying for Benefits	Yes	US Citizen	No
Pregnant	N/A	Ethnicity	N/A
Hispanic/Latino	Yes	Race/s	White


8/6/2014

Page : of 3

Legal Resident	No	Date of Entry into US	01/01/2014
Marital Status	Never Married	Insurance Company	N/A
Spouse Name	N/A	MRI	N/A
Receiving General Relief?	N/A	In a rehab program?	N/A
Pending Medi-Cal Case	N/A	Veteran of Armed Forces	N/A
Responsible for a child/dependant under the age of 21 who resides in her household	N/A	Sponsored	N/A
Sponsor's Family Size	0	Sponsor's Name	N/A
Sponsor's Total Income	N/A	Sponsor's Total Asset	N/A
Sponsor's Total Debt	N/A	Applied for Medi-Cal in last 6 months	N/A
Have pending Medi-Cal application	N/A	Medi-Cal case denied or discontinued	N/A
		Medi-Cal Denial Reason	N/A
		Has spent down all or some of the assets since discontinuance of his/her Medi-cal	N/A
Medi-Cal Discontinued Reason	N/A	Cost per month	N/A
Employer Paid Insurance	No	Future Reason for Termination of Coverage	N/A
Employer Paid Insurance Date Coverage Ending	N/A	Reason for Termination of Coverage	N/A
Employer Paid Insurance Date Coverage Ended	N/A	Disability Expected to Last	N/A
Has Disability	N/A	Ever Received Cash Aid,SSI,Food Stamps,Medi-Cal	N/A
Disability Start Date	N/A	Work More Than 100 Hrs.	N/A
Name used when Cash Aid, SSI, Food Stamps or Medi-Cal received	N/A	Name of Facility	N/A
Long Term Care	N/A	Entry Date	N/A
Return Home	N/A	Board Care	N/A
Return Home in 6 Months	N/A	Admission date	N/A
Name of Facility	N/A	Branch Name	N/A
Served in the U.S. Military	N/A	Injury/Disability during Military service	No
Military Start Date	N/A	Enrolled in school fulltime	N/A
Home care needed to feed, bathe or dress a household member	N/A	School Type	N/A
School Name	N/A	Has a lawsuit pending due to an accident or injury?	N/A
Living away from home	N/A		
Denied for any state or federal program	No	Medical Denied	No
		Medical Denial Other Reason	N/A
Medical Denial Reason	N/A	Medical Coverage Type	N/A
Medical Denial Date	N/A		
Has denial letter	N/A	Food Stamps Denial Reason	N/A
Food Stamps Denied	No	Food Stamps Denial Date	N/A
Food Stamps Denial Other Reason	N/A	CalWorks Denial Reason	N/A
CalWorks Denied	No	CalWorks Denial Date	N/A
CalWorks Denial Other Reason	N/A	WIC Denial Reason	N/A
WIC Denied	No	WIC Denial Date	N/A
WIC Denial Other Reason	N/A		

8/6/2014

Congratulations



LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES
COMMUNITY PARTNERS
MY HEALTH LA (MHLA)

MY HEALTH LA(MHLA) Program New Member Notice

MHLA Program ID#: 31900201019295149
MHLA Program Start Date: October 23, 2014

Dear John Doe,

Congratulations! You are now enrolled in the My Health LA Program

Please present this form at medical appointments until you receive your My Health LA Program ID Card. You can schedule a doctor's appointment by contacting your assigned Medical Home Clinic at the number below.

Medical Home/Clinic: VENICE-VENICE
Phone# 310-392-8636

Within the next few weeks, you will receive:

- An ID card that you should carry with you at all times. You will present this card each time you visit your Medical Home.
- A Member handbook that provides information on benefits and services provided by the program.

If you do not receive these items from the My Health LA Program within 30 days, please contact My Health LA Program's Member Service at (844) 744-MHLA (1-844-744-6452).

Changing Your Medical Home: You can change your Medical Home Clinic for any reason within 30 days of the date of this letter. After 30 days, you will not be able to change your Medical Home Clinic for twelve months, unless you move or have a life changing event. Call MHLA Member Services within 30 days if you wish to change your Medical Home. (1-844-744-6452).

Getting Medical Care: Your Medical Home is the first place you should call when you need care. You may not receive primary care services from any other health care provider other than at your Medical Home, unless your Medical Home refers you to that provider.

Prescription Medicine: Your Medical Home Clinic has a designated pharmacy of other resource for picking up prescription medicines. To find your pharmacy, call your medical home or call My Health LA Program Member Services at (844) 744-MHLA (1-844-744-6452).

If you have a life threatening emergency call 911

Member Services (844) 744-MHLA (1-844-744-6452)
Monday through Friday, 8:00am to 5:00pm
<http://dhs.lacounty.gov/MHLA>

- ✓ Once a participant is successfully enrolled in the MHLA program they will receive a Congratulations letter and a MHLA Participants welcome Package.

My Health LA Welcome Packet

Participants will receive a welcome packet with the following information and documents enclosed:

1. MHLA ID card with the following information on card
 - ✓ Person ID number
 - ✓ Medical Home Name, Location and Telephone Number
 - ✓ Member Services Telephone Number
2. A Pamphlet with the program's benefit information
3. MHLA Welcome Letter



Printable Blank MHLA Forms



Change Font Size [A](#) [A](#) [A](#) [A](#)

Print Blank Forms

You can print the following blank forms.

Program Name	Document
My Health LA	Sample Affidavit
My Health LA	Employer Statement
Healthy Kids	Healthy Kids Program Information
My Health LA	In-Kind Income Affidavit
My Health LA	Profit and Loss Statement
My Health LA	My Health LA Rights and Declarations

Language

Get Help

Next

Modify vs. Update

Difference between modify and application update:

- ✓ Modification is a change that impacts the eligibility status.
(i.e., Change in income, change in household size)
- ✓ Update is a change that does not impact the eligibility status.
(i.e., Update L.A. Address, Update typo in the spelling of a name)
- ✓ Every modification created will change the application number.

Who can Modify and/or Update?

- ✓ Certified Application Assistors/Certified Enrollment Counselors and CAA/CEC Supervisor have access to modify and update. No medical home changes can be made during the enrollment period, unless 90 days prior to Renewal date.
- ✓ Member Services has access to update demographics and change the medical home. For a participant to change their medical home after 30 days, they must meet one of the following reasons.

Modify vs. Update continued

Acceptable valid reasons for medical home change (for Member Services):

- ✓ Enrollment occurred in the last 30 days
- ✓ Change of Address (Home/Work)
- ✓ Due to a change in Medical Condition
- ✓ Due to change in Age or Personal Characteristic
- ✓ Deterioration of Relationship with Provider
- ✓ Closure of Clinic Site
- ✓ Management Approval

Modification Process

When to modify an application; Assistor should assist MHLA participants who are assigned to their medical home or who originally enrolled at their medical home with demographic changes to their application. This process is performed through the update process.

Applicants can contact their medical home to report a change in status, such as:

- ✓ Medical Home (Only During Renewal)
- ✓ Income
- ✓ Loss of Employment
- ✓ New Employment
- ✓ Marital Status Change

Renewal Process

My Health LA participants will receive reminder postcards 90 days prior to renewal, advising them to make an appointment as soon as possible to continue their eligibility with the MHLA Program. Participants seeking assistance at their current medical home or original MHLA enrollment site will not be turned away, even if they are requesting a new medical home.

- MHLA Participant with a signed Rights and Declaration (RD) on file should qualify to have one person in the household renew on behalf of everyone in the household, so long as all required documentation is provided for every member of the household.
- If a Participant signed a Rights and Declaration (RD) during the initial application process and there is no break in coverage the Participant is not required to sign another RD during the renewal.

* Reference Document: MHLA Provider Bulletin #5



Continue Renewal Process

- MHLA participants will receive Renewal reminder postcards 90, 60 and 30 days prior to their renewal date.
- The postcard includes instructions to contact their Medical Home to schedule an appointment for a renewal.
- The Participant may change their Medical Home for any reason during their renewal.
- Participants can renew for MHLA at any Medical Home.

Verification Required For Renewal

Participants must provide the following verification at time of Renewal:

- ✓ Income
- ✓ Residency
- ✓ New Changes (same as modification process)
- ✓ There is no need to request permanent documents (such as ID, passport, etc..) if already on file/upload, temporary documents (such as income and rent receipt) must be provided during annual renewal.
- ✓ Renewals made 90 days prior to renewal date will be issued a new application number and new coverage period will be effective as soon as original coverage ends.

Disenrollment Reasons

- ✓ Not a Los Angeles County Resident
- ✓ Enrolled in Public Coverage
- ✓ Enrolled in Employer-Sponsored Insurance
- ✓ Enrolled in Private Insurance
- ✓ Participant is Deceased
- ✓ Program Dissatisfaction (admin., services, medical home, etc.)
- ✓ False or misleading information on MHLA application
- ✓ Under Program Age Requirement
- ✓ Enrolled in Full Scope Medi-Cal
- ✓ Did not complete Renewal
- ✓ Determined Eligible for Other Programs During Annual Renewal or Modification
- ✓ Enrollee is incarcerated
- ✓ Income exceeds 138% of FPL
- ✓ Participant's request
- ✓ Participant has DHS Primary Care Provider
- ✓ Incomplete Application

My Health LA Re-Enrollment

Participants can re-enroll in the My Health LA Program after being disenrolled from the program by scheduling an appointment at a MHLA medical home clinic location. Re-enrollment in the program is contingent upon meeting all MHLA Program eligibility and enrollment criteria.

- ✓ Participants are not required to re-submit proof of identity if documentation is electronically stored.
- ✓ Enrollers are encouraged to update information as appropriate.
- ✓ Application Assistor will modify or update the application to reflect any recent demographic or household change.

Note: It is the enroller's responsibility to verify that the necessary documentation was scanned or faxed correctly and that it is clear and legible.

Applicants previously assigned to a Medical Home with a closed status (not accepting new applicants). Will be defaulted to the closed Medical Home, the new Medical Home will be effective the 1st day of the following month.

My Health LA Outreach

Participants can choose the following contact options:

- ✓ Telephone
- ✓ Postal Mail



Mailings

MHLA Program Administration mails All MHLA participants Welcome Packets within two weeks of enrollment and all renewal reminders starting 90 days prior to the end for their annual renewal date.

My Health LA Outreach

Centralized Mail and Phone Outreach

MHLA Program customizes additional renewal outreach to members based on their documented communications preferences.

- ✓ Phone: Participants who designate phone as their preferred mode of contact, will receive an automated phone call and a live telephone call prior to their annual termination date.
- ✓ US Mail: Members who designate US Mail as their preferred mode of contact, will receive a reminder postcard.

My Health LA Recap

MHLA Notices

- ✓ MHLA Rights and Declarations
- ✓ Congratulations Page
- ✓ Medi-Cal Referral Letter
- ✓ MHLA Denial Notice
- ✓ MHLA Pending Notice
- ✓ MHLA Application Summary
- ✓ MHLA Renewal Notices
 - a) 90 days prior
 - b) 60 days prior
 - c) 30 days prior

Able to process on One-e-app

- ✓ MHLA Application
- ✓ MHLA Update/modification
- ✓ MHLA Renewal
- ✓ MHLA Denial
- ✓ Generate Reports

Eligibility Requirements

- ✓ Reside in Los Angeles County
- ✓ Age 19 and older
- ✓ Income at or below 138%
- ✓ Uninsured

Criteria for Household Composition for My Health LA

- ✓ Only the incomes of those individuals counted in the family size are considered. An individual must live in the home to be part of the My Health LA family size, with the exception of children who are claimed as tax dependents and are away at school, and adults away for work who intend to return to the household. The chart below outlines countable family members:
- ✓ Spouses/domestic partners (certified or registered)
- ✓ Biological or adopted children under age 21 (0-21 inclusive, including unborn) living in the household or away at school and claimed as tax dependents
- ✓ Unmarried father of an unborn child (first month of pregnancy).

MHLA Household Size/Composition

Living Arrangement	Application(s) by CEC	Counted as/Budgetary Unit
Married or Certified Domestic Partners living together	One application	One household – HH of 2
Married or CDP living together with common children	One application	One household – HH of 2+
Married or CDP living together with step-children	One application	One household – HH of 2+
Married or CDP living apart*	One application	One household – HH of 2
Divorced partners living together	Two applications	Two households – HH of 1
Divorced partners living together with common children under 21 years of age	One applications	One household– HH of 3, 2 adults and one child+
Male living with Female	Two applications	Two households – HH of 1
Male living with 6 month Pregnant Female (his child)	One application	One household – HH of 3
Male living with 5 month Pregnant Female	Two applications	Two households – Male is HH1 Female is HH of 2
Male living with Female with common children	One application	One household – HH of 3+
Male living with Female with children not *related to one of the adults on the case	Two applications	Two Household – Male is HH1 Female is HH of 2+
Male living with Female with common and children not *related to one of the adults on the case.	One application	One Household – HH of 4+

***Related is defined as biological or adopted children under the age of 21 years old.**

***Applies to Married or CDP away for work who intends to return to the household.**

Immigrant - Categories

- ✓ Lawful Permanent Residents
- ✓ Lawfully Present Immigrants
- ✓ Permanent Residence Under Color of Law (PRUCOL)
- ✓ Refugee Medical Assistance
- ✓ Undocumented Immigrants
- ✓ Immigrants with Temporary Status

Immigrants Eligible for Full-Scope Medi-Cal

- ✓ Lawful Permanent Resident (LPRs)
- ✓ Individuals with work authorization
- ✓ Permanent Residence Under Color of Law (PRUCOL)
- ✓ Deferred Action for Childhood Arrivals (DACA)
- ✓ Asylees
- ✓ Cuban and Haitian Entrants
- ✓ Certain battered spouses and children
- ✓ Victims of Trafficking
- ✓ Individuals granted Conditional Entry
- ✓ Individuals granted Withholding of Deportation/Removal
- ✓ Individuals Paroled into the U.S. for at least one year
- ✓ Children under the age of 19 (Senate Bill (SB) 75)

Note: **The Qualified Immigrant categories above are eligible for full-scope Medi-Cal and therefore Ineligible for MHLA.**

Permanent Residence Under Color of Law (PRUCOL)

- ✓ Immigrants who are PRUCOL are eligible for full-scope Medi-Cal as long as they are otherwise eligible. Under PRUCOL, category #16 the immigrant is declaring that federal immigration authorities are aware of the immigrant's presence, but do not plan to remove him or her from the country.
- ✓ Under Permanent Resident Under Color of Law (PRUCOL), DACA individuals are considered to be legally present under Deferred Action Status. This population is eligible for state funded full-scope Medi-Cal.

Note: Individuals may apply through Covered California, or at DPSS.

Deferred Action for Childhood Arrivals (DACA)

Also referred to as the Dream Act – Eligibility Requirements

- ✓ Under 31 years of age as of June 15, 2012;
- ✓ Came to the U.S. while under the age of 16;
- ✓ Continuously resided in the U.S. from June 15, 2007, to the present;
- ✓ Entered the U.S. without inspection before June 15, 2012, or their lawful immigration status expired as of June 15, 2012;
- ✓ Physically present in the U.S. on June 15, 2012, and at the time of making the request for consideration of deferred action with USCIS;
- ✓ Currently in school, have graduated from high school, have obtained GED, or have been honorably discharged from the Coast Guard or Armed Forces; and
- ✓ Not convicted of a felony offense, a significant misdemeanor, or more than three misdemeanors and do not pose a threat to national security or public safety.

Lawful Permanent Residents

■ Lawful Permanent Residents – (LPRs)

Current Federal regulations establish a “5-year bar” for lawfully present immigrants in order to be eligible for Federal Medicaid.

However, in California, qualified immigrants who have not satisfied the “5-year bar” are eligible to receive State-only full-scope Medi-Cal.

Ineligible for MHLA

The following qualified immigrants and PRUCOLs are eligible for full-scope Medi-Cal benefits, therefore ineligible for MHLA:

- ✓ Individuals up to 21 years of age
- ✓ Pregnant women with income up to 60% of the Federal Poverty Level (FPL)
- ✓ Qualified immigrants who are pregnant with income over 60% and up to 213% of the FPL are eligible for pregnancy – only Medi-Cal.
- ✓ Children in families with income up to 266% of the FPL
- ✓ Parents, seniors, and persons with disabilities

Medi-Cal Eligibility

- ✓ As with all applicants, Medi-Cal expansion eliminates the linkage, deprivation, and assets requirements. It requires that qualified immigrants only meet the income and state residency requirement.
- ✓ Medi-Cal expansion covers eligible immigrants who are childless adults with income up to 138% of the FPL.
- ✓ Qualified immigrants who are pregnant may also be eligible for full-scope Medi-Cal benefits

Undocumented Immigrants & MHLA

- Undocumented immigrants include non-citizens without a lawful immigration status.
- Not eligible for Medicare or Full-scope Medi-Cal
- If all eligibility requirements are met, undocumented adult immigrants 19 and above will continue to receive:
 - ✓ Emergency Related Services
 - ✓ Pregnancy Related Services
 - ✓ State Funded Long-Term (LTC)
 - ✓ MHLA

Temporary Visa

- Applicants with temporary visas such as visitor's visa, student visas, are not typically eligible for Medi-Cal, unless they can establish that they intend to permanently reside in the state, and meet all other eligibility requirements.
- If eligible to Medi-Cal, they receive the same restricted-scope benefits as undocumented individuals.
- Applicants with temporary Visas who declare that they intend to reside in CA should be referred to apply for restricted Medi-Cal and enrolled into MHLA.

Enrollers: should note in the OEA note section that “applicant had decided not to return and intend to reside in California”.

- Individuals granted Temporary Protected Status (TPS) or have applied for TPS, have the same eligibility to programs as U.S. Citizens (based on their PRUCOL status), therefore ineligible for MHLA.

Coverage for Immigrants Under Health Care Reform

An alien admitted to the U.S. as a(n)

- Refugee
- Refugee-parolee
- Asylee
- Holder of a T visa
- Holder of a U visa
- Person granted conditional entry
- Certain Cuban and Haitian entrants, as well as persons whose deportation is being withheld
- Aliens lawfully admitted for permanent residence under the Immigration and Nationality Act (INA), 8 USC 1101 et seq

are considered as "qualified aliens". These qualified aliens should not be treated as MHLA eligible, simply because they have an Employment Authorization Document "work permit". If these persons are issued a work permit their status will be identified on the work permit by the following categories:

Coverage For Immigrants Under Health Care Reform cont.

1. A-3 – refugee
2. A-4 – parolee
3. A-5 – asylee
4. A-1 6 or A-25 - victims of human trafficking
5. A-1 9 or A-20 - victims of certain crimes
6. A-3 - persons granted conditional entry
7. C-1 1 or A-4 - certain Cuban and Haitian entrants
8. A-10 - those persons whose deportation is being withheld

Patients that prove that they live in LA County but have no visa, or an expired visa or work permit and who are not seeking to extend or adjust their prior lawful status are considered residents (undocumented) of LA County for the time period after their documentation expired and therefore, are eligible for MHLA.

Note: Persons who file for either an extension or adjustment of their immigration status, will continue to be treated as Lawfully Present Immigrants while waiting for a decision, even if their visa or immigration documents expire or have expired while their request is pending.

MHLA Earned Income Verification Guidelines

MHLA Earned Income Verification Guidelines (other than Self-Employment) is considered income received in cash as wages, salary, commission, Disability Insurance Benefits (DIB) – temporary, or person receiving Worker’s Compensation temporarily.

MHLA allowable Earned Income

- ✓ Cash Income
- ✓ Earnings from a job
- ✓ Fulltime Student Income
- ✓ Other Income
- ✓ Self-Employment
- ✓ Self-Employment – Partnership
- ✓ Worker’s Compensation

Calculating Income

1. The MHLA Program does not allow deductions
2. The MHLA Program allowable Income is calculated as follows:

- ✓ Monthly “X” 1
- ✓ Semi-Monthly “X” 2
- ✓ Bi-weekly “X” 2.167
- ✓ Weekly “X” 4.33

Note: Semi-monthly payment is defined as payment received twice a month on the same day, bi-weekly is defined as payment received every other week.

Acceptable Verification of Earned Income

Signed Statement from Employer

1. If appropriate paycheck stubs or tax returns are not available, send Employment Verification Letter requesting verification of income of employment to applicant's employer
2. Applicant may either take the letter directly to his/her employer or you can mail it to their employer
3. Also, a signed statement from the employer or organization providing the income is acceptable. The statement should include the following information:
 - ✓ Individual's gross earnings
 - ✓ Frequency of earnings
 - ✓ Employer's signature and the date signed
 - ✓ Employer's business address and phone number

Acceptable Verification of Self-Employed Income

1. Income from self-employment refers to cash received as profit from an activity such as a business enterprise, which is owned or controlled by the Applicant or responsible relative(s).
2. Net profit income from the self-employment activity is the amount to be used (i.e., gross profit and loss allowable business expenses).
3. Net profit income can be obtained either from last year's income tax statement or from current business records.

Acceptable Verification of Net Profit Income

1. Federal Income Tax Return

- ✓ The previous year's Federal Income Tax Return is to be viewed to determine the net profit.
- ✓ Net profit is used as an estimation of annual income for the current year.
- ✓ Annual net profit income is divided by 12 (months) to receive the monthly income.

2. Current Business Records

- ✓ Federal Income Tax return is the preferable type of verification, however if the applicant was not self-employed for the previous year, or did not file an income tax return, or the income tax return do not reflect their current income, current business records are an acceptable form of verification.

Profit and Loss Statement



PROFIT AND LOSS STATEMENT (EXAMPLE ONLY)

<Day>, <Date>
<Applicant's Name>
Application ID: <App Id#>
Member ID: <Member ID#>

Company Name: ABC Landscaping Company
Address: 1000 First Street
City, State, Zip: Los Angeles, CA 90022
Telephone: (323) 555-1234
Email: abcland@gmail.com

Expense :	Month: January 2016	Month: February 2016	Month: March 2016
Total Income:	\$4,200.00	\$3,600.00	\$6,200.00
Car	\$200.00	\$100.00	\$200.00
Equipment	\$1,000.00	\$900.00	\$1,000.00
Repair	\$300.00	\$2,200.00	\$100.00
Advertising	\$300.00	\$400.00	\$300.00
Depreciation	\$100.00	\$100.00	\$100.00
Meals & Entertainment	\$100.00	\$100.00	\$200.00
Cash Draw	\$1,000.00	\$1,000.00	\$2,000.00
Total Expense:	\$3,000.00	\$4,800.00	\$3,900.00
Net Income:	\$1,200.00	-\$1,200.00	\$2,300.00

The information provided above is true and correct to the best of my knowledge.

(Signature and date of Member Earning Income)

Please refer to the next page to see how MY HEALTH LA (MHLA) Program calculates your monthly income.

Profit and Loss Statement



HOW THE MHLA PROGRAM CALCULATES INCOME

* When calculating your income, the MHLA Program does not include depreciation, meals and entertainment, and cash draws as business expenses. The MHLA Program adds expenses for depreciation, meals and entertainment and cash draws back into your monthly income. These types of expenses are referred to as "Disallowed Expenses." Please see the example below.

** The MHLA Program counts negative amounts as zero (\$0). Please see the February 2016 income as an example.

Company Name: ABC Landscaping Company
 Address: 1000 First Street
 City, State, Zip: Los Angeles, CA 90022
 Telephone: (323) 555-1234
 Email: abcland@gmail.com

Expense :	Month: January 2016	Month: February 2016	Month: March 2016
TOTAL INCOME:	\$4,200.00	\$3,600.00	\$6,200.00
Car	\$200.00	\$100.00	\$200.00
Equipment	\$1,000.00	\$900.00	\$1,000.00
Repair	\$300.00	\$2,200.00	\$100.00
Advertising	\$300.00	\$400.00	\$300.00
Depreciation*	\$100.00	\$100.00	\$100.00
Meals & Entertainment*	\$100.00	\$100.00	\$200.00
Cash Draw*	\$1,000.00	\$1,000.00	\$2,000.00
Total Expenses:	- \$3,000.00	- \$4,800.00	- \$3,900.00
Net Income:	\$1,200.00	-\$1,200.00	\$2,300.00
Disallowed Expenses*	\$1,200.00	\$1,200.00	\$2,300.00
ADJUSTED NET:	\$2,400.00	-\$0.00**	\$4,600.00

MHLA Program monthly income calculations:

Net Profits:	January 2016	\$2,400
	February 2016 **	\$ 0
	March 2016	\$4,600
Total Net Profit:		\$7,000
Monthly Net Profit:	Divide by:	+3
		<u>\$2,333</u>

Please refer to the next page for a blank My Health LA (MHLA) Profit and Loss Statement.

Profit and Loss Statement



LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES
COMMUNITY PARTNERS
MY HEALTH LA

PROFIT AND LOSS STATEMENT

Date: _____
Applicant's Name: _____
Application ID: _____
Person ID: _____

Company Name:
Address:
City, State, Zip:
Telephone:
Email:

Expense :	Month:	Month:	Month:
Total Income:	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$
Total Expense:	\$	\$	\$
Net Income:	\$	\$	\$

The information provided above is true and correct to the best of my knowledge.

(Signature and date of Member Earning Income)

Acceptable Verification of Net Profit Income

Affidavit:

- ✓ An affidavit showing applicant's business income is acceptable verification if income tax return or current business records are unavailable.
- ✓ The affidavit must specify the gross income and expense amount, not an average of net profits, (e.g., I am a self-employed housekeeper and earn approximately \$500 monthly).

Note:

The applicant must be advised to maintain business records in the future and the affidavit must state that the applicant was advised to keep business records.

Unearned Income

Unearned income is defined as income that is not earned through labor or personal effort. Following are examples of unearned income:

- ✓ Unemployment Insurance Benefits (UIB)
- ✓ Disability Insurance Benefits (DIB)
- ✓ Social Security payment
- ✓ Veteran's payments
- ✓ Railroad pensions
- ✓ Contributions from any source
- ✓ Rental of property
- ✓ Interest Income
- ✓ Certain grants
- ✓ Support payments
- ✓ Permanently received Worker's Compensation benefits, etc.

Note: Unearned income generally is received monthly. An exception is UIB/DIB, which is considered to be a weekly benefit received biweekly. Exclude public assistance income (i.e., SSI/SSP, CalWorks, etc.)

Acceptable Verification of Unearned Income

1. Income Tax Returns
2. Copies of checks or check stubs
3. Other Documents: In the event that the applicant cannot provide a copy of their income tax returns, or copies of their check stubs they can provide one of the following documents:
 - a. Award Letter
Award letter is a notice sent to applicant listing the type of benefits, effective date, amount, and the frequency.
 - b. Signed Statement from person or organization providing income
A signed and dated statement from the person or organization providing the unearned income is acceptable verification.

Acceptable Verification of Unearned Income cont.

c. In-Kind Income

In-kind Income could be earned or unearned and generally are items such as free housing, utilities, and food.

- ✓ In-Kind clothing is no longer counted when determining In-kind Income.
- ✓ In-Kind Income Statement must be completed, signed, and sent to the provider.
- ✓ A ten (10) day control should be set for the return of the form, if the In-Kind Income form is not returned by the provider after ten (10) days, use the in-kind chart amount to process the MHLA application.
(see attached)

In-Kind Income Levels



FAMILY SIZE	HOUSING	UTILITIES	FOOD
1	\$153	\$ 33	\$ 86
2	\$ 206	\$ 38	\$ 182
3	\$ 225	\$ 40	\$ 232
4	\$ 236	\$ 41	\$ 286
5	\$ 236	\$ 41	\$ 346
6	\$ 236	\$ 41	\$ 401
7	\$ 236	\$ 41	\$ 447
8	\$ 236	\$ 41	\$ 490
9	\$ 236	\$ 41	\$ 537
10 or more	\$ 236	\$ 41	\$ 582



In-Kind Income Affidavit

In-Kind Income can be from anyone other than a responsible relative.



IN-KIND INCOME AFFIDAVIT

Please complete if you are providing support to an applicant for My Health LA (MHLA) program

Patient Name: _____
Member ID: _____

Dear _____

Your name has been given to us as a provider of in-kind income for the above-mentioned person(s)

Please complete the brief questionnaire and return it to my attention as soon as possible using the enclosed, self-addressed envelope.

Thank you in advance for your cooperation.
Very truly yours,

California Enrollment Counselor

Date

Please complete: Person Providing Support:

Last Name:		First Name:		Phone: ()	
Street Address:			City:	State:	Zip:
I am providing: (Check all that apply)	Utilities <input type="checkbox"/>	Food <input type="checkbox"/>	Housing <input type="checkbox"/>	Cash Amount <input type="checkbox"/> Please specify amount and frequency: _____	
I expect to provide items (for how long?)			Please choose one: Earned <input type="checkbox"/> Free <input type="checkbox"/>		
Is applicant residing with provider? Yes <input type="checkbox"/> No <input type="checkbox"/>					
I declare the answers given are true and correct to the best of my knowledge. I understand the information provided will be used to screen the applicant for eligibility to various Federal, State, and County Programs. I understand that I will not be held responsible for any fees for medical services received by the applicant.					
Signature of person providing support			Date		

Applicant Receiving Support:

I declare the answers given are true and correct to the best of my knowledge. The information provided will be used to screen for eligibility to various Federal, State, and County Programs. I understand that if the information is found to be false, I will be held responsible for the full amount of fees for medical services received.

Signature of Applicant

Date

Excluded Income

1. Earned Income of Children

- ✓ When the income of a child under 14 years of age is received from earnings, the amount is to be excluded. The parent's statement that the income is from earnings is acceptable verification.
- ✓ When a child between 14-18 years of age has earnings and the child is attending school full time, their income is to be excluded. The parent's statement should include that the income is from the child's earnings and that the child is a full-time student is acceptable verification.
- ✓ These statements must be documented.

2. Educational Grants

- ✓ Only that portion of the grant, which is specifically for educational purposes (e.g., tuition, books, etc.), can be exempt. Count as income only that portion which is for personal use, (e.g., housing, food, utilities).
- ✓ Note: Educational grants may be verified by viewing the grant document to determine its exempt or nonexempt status. Document how the grant was evaluated to determine its exempt or nonexempt status. Whenever possible, a copy of the grant document is to be retained.

Education loans should not be considered income to the extent they are required to be repaid.

Excluded Income Continued

1. General Relief (GR)

- ✓ Anyone applying for GR needs to be a U.S. citizens or legal alien and must show proof of authorization of residence from the INS, making them ineligible for the MHLA Program.

2. CalWORKS

- ✓ Benefits received from CalWORKS are entered under the children's income and divide evenly between the children receiving benefits.

i.e. Huey (undocumented), Duwey (documented) and Luwey (Documented)

CalWORKS received: \$500

Huey does not receive income, therefore it is divided by two and entered under Duwey and Luwey.

2016 FPL Calculation Chart (Monthly Values)

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICE

ABILITY-TO-PAY PLAN

138 % FEDERAL POVERTY LEVEL (FPL)

(Effective April 1, 2016 through March 31, 2017)

FAMILY MEMBERS LIVING IN THE HOME ¹	TOTAL MONTHLY INCOME MAXIMUM ²
<input type="checkbox"/> 1	at or below \$1,367
<input type="checkbox"/> 2	at or below \$1,843
<input type="checkbox"/> 3	at or below \$2,319
<input type="checkbox"/> 4	at or below \$2,795
<input type="checkbox"/> 5	at or below \$3,271
<input type="checkbox"/> 6	at or below \$3,747
<input type="checkbox"/> 7	at or below \$4,224
<input type="checkbox"/> 8	at or below \$4,703
<input type="checkbox"/> 9	at or below \$5,181
<input type="checkbox"/> 10	at or below \$5,660
<input type="checkbox"/> 11	at or below \$6,138
<input type="checkbox"/> 12	at or below \$6,616

More than 12 Members

For each additional member, add \$479

¹ Include unborn and domestic partners in family size.

² For ATP, all deductions are eliminated:

- \$90 per working person
- Child Care
- Medical Insurance expenses
- Alimony/Child Support Paid

2016 FPL Calculation Chart (Annual Values)

	100% FPL	ANNUAL FPL VALUES (Rounded up to next higher dollar)										
Family Size	Annual FPL	60%	100%	108%	109%	114%	120%	128%	133%	135%	138%	142%
1	11880	7128	11880	12831	12950	13544	14256	15207	15801	16038	16395	16870
2	16020	9612	16020	17302	17462	18263	19224	20506	21307	21627	22108	22749
2 Adults	16020	9612	16020	17302	17462	18263	19224	20506	21307	21627	22108	22749
3	20160	12096	20160	21773	21975	22983	24192	25805	26813	27216	27821	28628
4	24300	14580	24300	26244	26487	27702	29160	31104	32319	32805	33534	34506
5	28440	17064	28440	30716	31000	32422	34128	36404	37826	38394	39248	40385
6	32580	19548	32580	35187	35513	37142	39096	41703	43332	43983	44961	46264
7	36730	22038	36730	39669	40036	41873	44076	47015	48851	49586	50688	52157
8	40890	24534	40890	44162	44571	46615	49068	52340	54384	55202	56429	58064
9	45050	27030	45050	48654	49105	51357	54060	57664	59917	60818	62169	63971
10	49210	29526	49210	53147	53639	56100	59052	62989	65450	66434	67910	69879
11	53370	32022	53370	57640	58174	60842	64044	68314	70983	72050	73651	75786
12	57530	34518	57530	62133	62708	65585	69036	73639	76515	77666	79392	81693
Ea Add'l	4160	2496	4160	4493	4535	4743	4992	5325	5533	5616	5741	5908

Household Composition Examples

Example 1

Single Female (undocumented) and 3 children (2 U.S. born and 1 Undocumented child, all children are over the age of 6 years old), unemployed and living with her parents. Children do not have any state program or private insurance.

Eligibility Outcome?



Outcome Example 1

Outcome: Income is at or below 138 % of the FPL, HH is receiving in-kind income. Female is eligible to MHLA, entire household should be referred to Medi-Cal. The children should be eligible to full scope Medi-Cal.

Household Composition Examples

Example 2

Single male (undocumented), living with his girlfriend (undocumented) both are applying for MHLA. He is employed and is paid weekly the amount of \$300.00, female is unemployed. Both have not applied for Medi-Cal nor have private or employer provided insurance.

Eligibility Outcome?

Outcome Example 2

Outcome: This case requires two applications, male is a HH of 1 and female is a HH of 1. Income is at or below 138% of the FPL for a HH of 1 (male's income is factored by 4.33 = \$1,299.00 monthly), and female is receiving in-kind from boyfriend, both are eligible to MHLA and should be referred to apply for restricted Medi-Cal.

Household Composition Examples

Example 3

Homeless single male (undocumented), applicant's means of support is pan handling and staying at shelters in Los Angeles County and does not have a mailing address. Male request to have his mail be sent to his medical home. He has not applied for Medi-Cal nor has any other type of health insurance.

Eligibility Outcome?

Outcome Example 3

Outcome: Income is at or below 138% of the FPL for a HH of 1, applicant is homeless with no income, requires an affidavit of means of support. Applicant is eligible for MHLA and should be referred to apply for restricted Medi-Cal.

Household Composition Examples

Example 4

Married couple with an 18yr old son away at school, household resides in LA County. Father is employed and is paid monthly the amount of \$1000. Son is receiving financial aid in the amount of \$2000 quarterly, and \$700 is used for personal use. Couple is undocumented and son is a U.S. born. Couple has not applied for Medi-Cal, son has full scope Medi-Cal.

Eligibility Outcome?

Outcome Example 4

- Outcome: Parents eligible for MHLA due to income being at or below 138% of the FPL for a HH of 3. Son's income is excluded due to him being between the age of 14 to 18 years of age and is a fulltime student. Parents should be referred to restricted Medi-Cal.

Household Composition Examples

Example 5

Certified domestic partners Tom and Jerry with one adopted child under the age of 6 yrs. Tom is employed and is paid biweekly the amount of \$1000. Household resides in LA County. Income was factored as followed: $1000 \times 2.167 = \$2167.00$ monthly. Jerry is unemployed. Entire household is undocumented. They have restricted Medi-Cal, the child has Full-Scope Medi-Cal.

Eligibility Outcome?

Outcome Example 5

- Outcome: One application is required for this scenario. Both Tom and Jerry are eligible for MHLA due to income is at or below the 138% of the FPL for a HH of 3. Medi-Cal referral is not necessary for this HH.

Household Composition Examples

Example 6

Unmarried couple with two adult sons (ages 21 and 22) in common, living in the same home in LA County. Father is employed and is paid \$300 weekly. Mother is unemployed. Eldest son is employed and is paid \$250 weekly. Youngest son is unemployed. Entire household is undocumented. Household has never applied for Medi-Cal.

Eligibility Outcome?

Outcome Example 6

Outcome: Four applications are required for this scenario. Father is a HH of 1 and income is factored as followed: $\$300 \times 4.33 = \1299 monthly. Mother is a HH of 1, is receiving in-kind from her partner. Eldest son is a HH of 1, and income is factored as followed: $\$250 \times 4.33 = 1082.50$ monthly. Youngest son is a HH of 1, and is receiving in-kind income from father. All applicants should be referred to apply for restricted Medi-Cal.

Questions?



MHLA
Q & A



MHLA Contact Info

SME Hotline: (626) 299-4388

Member Services: (844) 744-6452

MHLA ERU Manager: Barbara Marshall (626) 299-7274

One-e-App Help Desk - 1-866-429-1979

Hours of Operation: 8am to 5pm PST

SME Contact Info

- Roy Barker (626) 299-3358 rbarker@dhs.lacounty.gov
- Roberto Hubbard (626) 299-3361 rhubbard@dhs.lacounty.gov
- Victor Johnson (626) 299-5719 vjohnson5@dhs.lacounty.gov
- Eriberto Lawas (626) 299-5503 elawas@dhs.lacounty.gov
- Marie Quesada (626) 299-5515 mquesada@dhs.lacounty.gov
- Paula Ramos (626) 299-5720 paramos@dhs.lacounty.gov
- Ernesto Reynoso (626) 299-5523 ereynoso@dhs.lacounty.gov
- Petra Ornelas (626) 299-5718 peornelas@dhs.lacounty.gov